DERMATOLOGY MEDICAL HISTORY

Patient Name:_____DOB: _____DATE: _____/_____/_____

Referring Provider: _____ Phone # _____

Primary Care Provider: _____ Phone #_____

Name of Pharmacy: _____ Phone #_____

Reason for your visit: _____

Are you allergic to any medications? (circle one, if YES please list) YES NO _____

Have you ever had a bad reaction to dental anesthesia? (circle one) YES NO Never had dental anesthesia

List all Medications you are currently taking (including prescription, over the counter, vitamins, and herbals)

1: _____ 2: _____ 3._____

4: _____ 5:_____ 6:_____

Do you have now or have you ever had diseases or conditions of: (please check yes or no)

Lungs:

Bronchitis	Yes___ No___
Emphysema/COPD	Yes___ No___
Asthma	Yes___ No___

Heart:

High Blood Pressure	Yes___ No___
Heart Attack	Yes___ No___
Cholesterol Issues	Yes___ No___
Heart Murmur	Yes___ No___
Irregular Heartbeat	Yes___ No___
Blood Clots	Yes___ No___
Pacemaker	Yes___ No___
Coronary Artery Disease	Yes___ No___

Endocrine:

Diabetes	Yes___ No___
Thyroid (Hyper or Hypo)	Yes___ No___
Kidney	Yes___ No___
Dialysis	Yes___ No___

Cancer:

Type of Cancer: _____

Infectious Disease:

HIV/AIDS	Yes___No___
HEP B	Yes___ No___
HEP C	Yes___ No___

List Major Surgeries and the year they were performed:

_____

GI:

Reflux	Yes___ No___
Stomach Problems	Yes__ No___
Irritable Bowel	Yes___ No___

GU:

Bladder Problems	Yes___ No___
Yeast Infections w/Antibiotics	Yes___ No___

Rheumatologic:

Arthritis	Yes___ No___
Artificial Joint	Yes___ No___

Neurologic:

Memory Problems	Yes___ No___
Hearing Loss	Yes___ No___
Seizures/Fainting	Yes___ No___
Headaches	Yes___ No___
Stroke	Yes___ No___

Psychological:

Depression	Yes___ No___
Anxiety	Yes___ No___

Other:

Enlarged Lymph Nodes	Yes___ No___
Excessive Weight Loss	Yes___ No___
Flu Vaccination Yearly	Yes___ No___

65 years & Older:

Pneumonia Vaccination	Yes___ No___

Skin:

History of Skin Cancer	Yes___ No___ if yes type:_____
Family History of Skin Cancer	Yes___ No___ if yes type:_____
History of a Skin Disease	Yes___ No___ if yes type:_____
Problems with Healing	Yes___ No___
Do you bleed easily?	Yes___ No___
Develop rashes to bandages or Neosporin?	Yes___ No___

Women: Are you Pregnant? Yes___No___ **Are you Breastfeeding?** Yes___ No___

Smoking Status: *(circle one please)* Never Current Former

What is your occupation? _____ Hobbies? _____

Patient Signature:_____DATE: _____/_____/_____

Pediatric Patients Only: Height_____ Weight_____